U.S. NAVY MEDICAL DEPARTMENT ORAL HISTORY PROGRAM

ORAL HISTORY WITH VADM (ret.) HAROLD M. KOENIG, MC, USN
32nd SURGEON GENERAL OF THE NAVY and 36TH CHIEF OF BUMED

CONDUCTED BY
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23 SEPTEMBER 2015
TELEPHONIC

OFFICE OF MEDICAL HISTORY
BUREAU OF MEDICINE AND SURGERY
SKYLINE COMPLEX, FALLS CHURCH, VIRGINIA

The date is the 23rd of September, 2015. I'm here joined by Colonel Ginn, and today we have the honor of speaking with the 32nd Surgeon General of the Navy, Vice Admiral Harold Koenig. This session is being conducted as part of the BUMED Oral History Project.

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AS: Admiral, we really appreciate your time today. Thank you very much for being a part of this project.

Oral histories are first and foremost narratives and all narratives must have a beginning. We would like to start off with your beginnings, if you will. I know you were born and raised in Salinas, California. Can you talk a little bit about that and some of your early memories?

A: I was born in Salinas 21 months before World War II broke out. I lived there until I was three. My dad was a math teacher at Salinas High. He volunteered to join the U.S. Navy. That began travel across the United States and back through the war years. We didn't return to Salinas until 1946.

My dad was a commissioned officer. He went to Guam in early 1945 as an anti-submarine warfare officer. The family initially spent the war years in cities on the East Coast,

and then moved back to the West Coast. We lived with his sister and her family in Madera in the California's Central Valley until late 1944 when military housing became available to us in Richmond,[1] California. I attended kindergarten there. I remember Army convoys passing right by the apartment we lived in in Richmond; that was on San Pablo Avenue, which was essentially U.S. Route 101. The convoys were on their way to load on ships to be transported to the Pacific.

My dad was stationed on Treasure Island[2] in San Francisco Bay until early 1945. I remember riding across the Bay Bridge frequently. Looking down at the water, there were so many ships it looked like you could walk from ship to ship. I have a lot of other memories of the war and how it impacted us. There were gun emplacements along the coast and we frequently had blackouts at night. We collected tin cans, tin foil, lard and string for re-cycling. We had ration books for food. There were no new cars and the only replacement tires you could get were re-treads. To me that was the normal world.

[1] Richmond, California, was a shipbuilding hub in World War II employing thousands of workers and producing hundreds of Victory and Liberty ships for the war effort.

[2] An artificial island constructed in San Francisco Bay for the 1939 Golden State International Exposition or World's Fair. The island later served as home to the Naval Station and Naval Hospital/Clinic (1942-1995).

AS: Did your father ever talk about his experiences in the Navy?

A: Yes, he did. He talked about his time on Guam, which even though the war was not over, he enjoyed. There was no fighting on Guam by the time he arrived there. Along with Tinian and Saipan, Guam was a huge B-29[3] bomber base, and so he was a regular observer of the comings and goings of these aircraft. He was there when the war ended.

He got into "skin diving," and he brought back a large collection of seashells from the South Pacific, that you wouldn't be allowed to touch today. He was very dedicated and loyal to the United States Navy and he stayed in the Reserves until his death.

He died of acute leukemia in 1957, at the start of my senior year of high school. From the time he was diagnosed he lived only three months. This brings up an interesting question: why did I become a doctor? I had never thought about going into medicine nor had I thought of going into the Navy.

[3] The B-29 Superfortress was a four-engine propeller-driven heavy bomber designed by Boeing. It was flown primarily by the United States during World War II and later in Korea.

At age 14 I began working to earn money for college. Having become an Eagle Scout I worked one summer at a Boy Scout Camp and then three summers in agriculture, working 10-11 hours a day, 6 days a week along side the Braceros. I made $0.90/hour the first year and got a $0.10/hour raise each year.

After my father's death I went to my high school counselor's office to plan what I would do after graduation I had always wanted to go to Stanford, so I filled out an application. I got a full-tuition scholarship! While visiting my counselor I spotted a catalogue about the Naval Academy and I thought, "I'd like to look at that." I applied for admission to the Naval Academy. About a week after I graduated from high school I got a telegram saying that I had been accepted to go there as a "qualified alternate."

I had a quick decision to make, take my full-tuition scholarship to Stanford or go to the Naval Academy? My mother was a first grade school teacher and we had just a small amount of insurance money from my dad. I knew it was going to be financially difficult for my mother to put both me and my sister through college, so I decided to go to the Naval Academy. I left for Annapolis two or three days

later, and was sworn in on June 30th, 1958 along with 1,073 other young men.

During Plebe Summer we were organized into companies, each with a company officer who had just graduated in the Class of '58. My company officer was Ensign Charles Larson.[4] He will appear again later in this narrative.

I had a hearing problem that got in my way, and I tell people that I "bilged out" of the Naval Academy because I couldn't pass the hearing test. I was worked up at Bethesda; they took an exploratory look into my inner ear and told me I was going to be totally deaf in that ear. They said I could not stay in the Navy and for draft purposes I would be "4F."[5] That meant that I wasn't draft eligible. I left the Naval Academy at the end of plebe year. Bethesda is where I first started getting interested in medicine.

So with my 4F draft card in my wallet I headed home and searched for a place where I could go to school that I could afford. For the next couple of summers I worked in the County Hospital in Salinas as an orderly, earning money

[4] ADM Charles Larson (1936-2014). Two-time Superintendent of the Naval Academy (1983-1986; 1994-1998).
[5] Part of military classification system in effect from 1948-1975. "4F" denoted that the registrant was not "acceptable for military service." To be eligible for class 4F, a registrant must have been found not qualified for service in the Armed Forces by a Military Entrance Processing Station (MEPS).

for college. I attended Brigham Young University in Provo, Utah, even though I wasn't a Mormon. It was church supported so had a low tuition. I was able to finance my way through college with my summer jobs and working at the University during the year. I took out no loans. I got a Bachelor of Science degree in chemistry and qualified for minors in six or seven subjects.

Early in my last year of college I applied to eight medical schools. I was accepted to two — the University of Utah and Baylor[6]— during the first week of October, which was early acceptance. I had spent three years in Utah with the Mormons and enjoyed it. I didn't accept their theology, so I had not converted but had great respect for them. I decided to try medical school with the Baptists at Baylor.

DG: Was your hearing ever corrected surgically, or any other way?

A: Oh no. I'm now totally deaf in my left ear, as was predicted when I left the Naval Academy. Later in my career the ENT docs at Bethesda talked about sending me to

[6] M.D., Baylor University College of Medicine, 1966

Walter Reed because it had the lead on audiology. They suggested getting me a set of glasses that had a receiver in the left temple that would pick up sound on that side and transmit it around to the right temple, where I would hear it in my right ear. I asked, "How do people accept this?" They said, "About 99% of the people they try this on throw them away within the first two weeks." I said, "Guys, don't waste money on this." I've been through college, medical school and a medical career dealing with this and survived."

I did have problems because of my hearing. I didn't like talking on the telephone because doing so would cover up the only ear I could hear with, and thus I had little auditory sense of what was going on around me. The other problems it caused were social in that people would say something to me, and if they were on my left side I wouldn't hear them and they thought I was ignoring them. I always tried to remember to tell people that I had this hearing problem. When you're a flag officer you go to a lot of social events. I always tried to tell my dinner partner on my left about this problem. My wife and I got to the point where she would sit on my left side so that she could

alert me if somebody said something to me from that side of the table. That was a struggle that I always had.

DG: Your comments on hearing strike me. My mother had a dear friend from college who was hard of hearing, who always supported Gallaudet College here in Washington. It struck me early on that deafness is one of the few disabilities that can really annoy other people, because they have to speak up louder, or they think that you're ignoring them and so forth. It struck me always that with that disability you take on an added burden because you have to deal with the reaction of other people.

A: Yes, and it's something that I'm aware of constantly.

I told you my dad was a math teacher and what happened to him. My mom was a first grade teacher and she taught until she was in her mid-60s. She lived to be 99 and a half, all the time except for her early life and the war years, in Salinas. She was alive when I retired from the Navy; and that was one of the reasons that we located to the West Coast. I have one sister; her name is Elaine - she's three years my junior and she lives in Montana.

AS: Admiral, growing up, did your parents impart any advice to you about what you should be doing in your future?

A: No, there was no pressure about what I should do after high school other than I was expected to go to college. My father was probably the first person in his family to graduate from high school; he got a teaching certificate from Fresno State College. He grew up in Madera — a small California Central Valley town. After graduating from Fresno State in 1931 he got a teaching job in Salinas.

My mother was the last of seven children, the only one born in the United States. Her mother had emigrated from the Azores to New Bedford, Massachusetts after the birth of her sixth child and her husband had left for America and died in an accident. My mother was born six or seven years later. We have no idea who her father was. Her birth certificate says, "Father Unknown." She and her mother moved to California when my mother was in junior high because two of her brothers had joined the U.S. Navy and were stationed on the West Coast. Her mother worked as a domestic, cleaning people's houses, cooking, and doing laundry. After high school, my mother lived in Hayward with her mother and attended San Francisco City College. She rode the ferry across the bay daily to attend college. This was before the bridges were built. She had her teaching certificate by the time she was 21, and got a job in

Salinas after a couple of years of teaching in the Bay Area. She and my father met and got married, and I was their first-born.

I didn't make the decision to become a doctor until I left the Naval Academy and knew that I wasn't going to be a naval officer. This brings me to another interesting story — how I wound up back in the Navy.

Recall, I was 4F. It turns out that in the draft law at the time, there was an exception if you were a doctor. Doctors who were 4F, were still draft eligible. When I started my third year of medical school I got a letter from my draft board saying that the dean had sent them a letter saying that I would graduate in June of 1966. All medical school deans had to do that for all the males in their school. I was not expecting to go back into the military. I planned to do my residency and go into.

Deena and I met on a blind date during the summer between my first and second year of medical school while I was working in Pathology at the local VA Hospital. After a year of dating we wanted to get married, but we couldn't afford it. But, I learned if I signed up for the Navy Senior Medical Student Program, my senior year of medical school would be paid for and I'd have a paycheck. Knowing I

would be drafted, I signed up. The Senior Medical Student Program preceded the current HPSP Program.[7] It was a really neat program because you were commissioned as an Ensign during your senior year of medical school and were on active duty, and it counted for retirement!

DG: There was just a little short period of time you could do that. It's kind of neat.

A: Yes, the dentists used it for quite some time, longer than physicians did.

DG: How was medical school? Any ups and downs?

A: I wasn't the star student, but I certainly wasn't the anchorman either. It was not until my senior year that I made a decision that pediatrics was the specialty I wanted.

Early in my senior year of medical school I applied for internships. One of the requirements of the Senior Medical Student Program was that you had to apply for a Navy internship, so I did. I also applied for others including pediatrics at Baylor, and I got accepted to that.

[7] HPSP (Health Professions Scholarship Program). A four-year scholarship in which the Navy pays for medical school tuition and expenses. HPSP students are committed to four active duty tours of 45 days each year of medical school and four years on active duty as an armed forces physician, and four years of inactive reserve duty. The Navy awards about 200 HPSP scholarships each year.

I got accepted for a Navy internship too, but I did not choose it because I thought I was just going to do my three years of obligated service and get out.

It didn't work out that way. Towards the end of my internship, I was told I would be going to Japan. We were married by that point[8] and went to Sasebo, Japan where I served as general medical officer at the Fleet Activity Unit there.[9] We had a small hospital with eight doctors. We had a senior medical officer who was a classic ROAD (Retired On Active Duty) officer. This guy had come in the Navy during World War II. He did absolutely nothing. He even had a corpsman[10] deliver his mail to his quarters daily. We would see him at the hospital maybe once a week. He spent most of his time antique shopping during his four years there. If there's a point that you are going to ask me about people who influenced my career, this guy really did. My opinion was "I don't want to be like this guy." He had been an orthopedist. I think the whole time I was there I got him to look at one x-ray. We had an internist, a

[8] VADM Harold and Deena Koenig originally met on a blind date. They married at the beginning of his senior year of medical school in 1965. At the time of this interview the Koenig had just celebrated their 50th wedding anniversary.

[9] VADM Koenig served as General Medical Officer, Fleet Activities, Sasebo, Japan from 1967 to 1969.

[10]

surgeon, an obstetrician, a pediatrician, and three GMOs. Because I had had a lot of OB experience in medical school — I delivered over 300 babies in medical school - I was made the assistant to the obstetrician. You'd think normally that would be the surgeon, but the surgeon we had there had trained in a VA in Harlem, and he had claimed to have never taken care of a female patient, so he knew nothing about OB. I ended up becoming the assistant to the obstetrician as well as the assistant to the pediatrician, and the assistant to the surgeon. The other GMO's didn't want to do anything except military sick call, so I did all the other stuff, and military sick call, too. I got a lot of experience during those two years delivering babies, assisting on a lot of surgical cases, and seeing a lot of sick kids. I had a wonderful time in Sasebo, Japan.

I owed three years to the Navy and I thought I'd do my three years in Sasebo, get out and go back to Houston, do one more year of residency and go into practice. I had a position saved for me in the River Oaks[11] area of Houston. That was my plan but it didn't work out. Halfway through the second year a message came in from BUMED that said they were looking for people to apply for residencies in certain

[11] River Oaks is a residential area in central Houston established in the 1920s and known for being one of the wealthiest and most expensive communities in Texas.

specialties, that included pediatrics. They especially wanted guys like me with obligated service. I knew I wanted to be a pediatrician, so I talked to the pediatrician in Sasebo who had trained in Bethesda, and he said, "Why don't you just apply for it? They won't take you, but let them know you're interested in case you decide to do it next year." So I applied for it and they sent a message to me 24 hours later, "You're accepted to start in San Diego in July." We left Sasebo after two years and went to San Diego, and I did my pediatrics residency there.

I already had a lot of experience in pediatrics at this point because of my internship[12] in Houston, and my time in Japan. I went through the first year in San Diego doing all the rotations that everyone does. I was not quite halfway through the second year when the chairman of the department, Captain Jack Schanberger, said he wanted to talk with me about my future. I had already said that when I finished residency, I wanted to go back overseas as a general pediatrician. I had filled out my "dream sheet" and listed Rota and Naples as places I wanted to go. We had one child by that point and the second one on the way and we thought, while the kids are young it will be great; we'll

[12] Pediatric Intern, Ben Taub General Hospital and Texas Children's Hospital, Houston, TX, 1966-7

go overseas again and have a great time. I'll do my obligated service, come back, get out and go back to Houston.

That, again, didn't work out because the chairman said, "We need somebody dedicated to take care of the kids with blood diseases and cancer. The American Board of Pediatrics said every program has to have a doctor primarily responsible for these kids." He asked, "Would you consider staying one more year and doing that while we try and get one?"

Deena and I talked it over and agreed. I started taking care of these kids, primarily flying by the seat of my pants, and getting a little help from the hematologist at the University of California, San Diego. About halfway through the first year Captain Schanberger said, "A year from now, The American Board of Pediatrics is going to offer boards in Hematology-Oncology, I want you to take them."

I said, "You've got to be kidding me. I'm not fellowship trained. I'm basically self-trained. I'm just a general pediatrician doing this on my own."

He said the Navy was planning to start a fellowship in adult hematology-oncology and they could stick me in that for a year. So they farmed me out to Internal Medicine, and I spent a year in doing hematology-oncology on adults as well as children. I studied very hard. I took the boards and I scored in the 90th percentile. About 400 people took the exam, and about 250 passed it. All of a sudden, I was one. That's what got my career started in pediatric-hematology-oncology.

DG: In that specialty, you deal with very sick children, and sometimes the saddest of all the cases. That to me would be a specific burden in that specialty. How did you deal with that?

A: When I started in the specialty a diagnosis of one of those conditions meant a life expectancy of no more than two years. I remember talking to parents and they'd ask, "How long does my child have?" I'd say I would do the best I could for the child during the time they had left to try and keep them as healthy as possible so they could enjoy life. I think this is one of the reasons the chairman asked me to do this, because my philosophy was quite different from most of the other physicians. I felt that the children should be out of the hospital as much as possible; whereas,

the other guys would admit them and keep them in the hospital until they went into complete remission. I felt the children should be having fun and doing as much as they possibly could. I made house calls and tried to make their lives as normal as possible. That's how I dealt with it.

DG: You made it normal for the family, too, as much as you could.

A: Yes, and I tried to make everything as good as I could for the child and family because these kinds of conditions don't affect just one person, they affect the whole family constellation. That was the way I looked at things, and that was different from the thinking of the day.

I was fortunate because that was just the beginning of when we started to actually cure some kids. Some of my earliest patients were among the first children that were ever cured. I had one boy, Kenny Jensen, who had just turned one-year old when we diagnosed acute lymphocytic leukemia. Last year Kenny, now an attorney, his wife, his parents, and his five daughters came to dinner at my home. Another one of my early patients, Kathy Long, was 12 years old at diagnosis; she's now a grandmother. A third patient, Megan Dalton was four when we found she had a rare liver tumor. Despite heroic efforts, she passed away. I'll

return to her parents, LCDR Hank and Penny Dalton later in this narrative.

I lost a lot of other kids too. I went to their funerals, which was virtually unheard of. That wasn't considered a doctor's role. I disagreed with this practice and believed it was part of my role because I'd become an important part of these family's lives. That was a really hard thing to do.

I trained three guys in the specialty,[13] and we focused on trying to take care of the kids at the big hospitals - San Diego, Bethesda, Portsmouth and Oakland. That was in the early days of the Exceptional Family Member Program.[14] We got the services to transfer the families of kids with oncologic problems to us from all over. I did that until 1980, my plan at that point had matured to putting in my 20 years of service and retiring. I was hoping that I would be able to do it all in San Diego, and I didn't see any reason why they would transfer me anywhere else.

[13] VADM Koenig served as Head, Pediatric Hematology-Oncology Division, Naval Hospital, San Diego, CA from 1973-1980.

[14] Exceptional Family Member Program (EFMP) was designed to assist sailors with the special needs of their "Exceptional Family Members" (EFM), at new duty locations. Assistance is emphasized in the assignment process, but also includes family support from Fleet and Family Service Centers.

Someone who really influenced me in my career ne was Admiral J. William Cox.[15]

AS: The surgeon general?

A: Yes, Bill Cox. Bill was the CO the last two years I was in San Diego as a staff physician, 1978-1980. After he'd been here almost a year I was called to his office. Now, when you got called to the Admiral's office and you were a Commander, you probably were going to need to change your skivvies afterwards. I went to Bill's office and he says, "Harold, I want you to do something for me next year. I want you to be the intern coordinator." We had about 100 interns at Balboa. He said, "I want you to run a course to teach them about becoming a Navy medical corps officer. I want it to meet every Saturday morning for an hour. I want attendance taken."

I got the curriculum from the fellow I was relieving and started the training. We trained these officers through the entire year. They didn't like it because a lot of them had hoped they wouldn't have to come in on Saturdays, but I took muster and I wrote it down if they missed a session.

[15] VADM J. William Cox (1928-2003), Surgeon General of the Navy, 1980-1983

Then they had to do a research report for me on the subject. I scheduled uniform inspections every month and they had to go to every one of them. The reason for that is in the Navy we have a lot of uniforms - khakis, whites, blues, etc. A lot of these guys didn't get all those uniforms. They wanted to wear scrubs. I made sure every one of these guys had a complete "sea bag."

Blues were the most expensive uniform; a couple of guys didn't have them for the inspection. They didn't have to appear before me - they had to appear before Bill Cox, and they were given one week to get the uniform or they were going to go to mast and they were going to be fined. You can take a half a month's pay for two months from these guys and so we really made things tough; we tightened the place up a lot during Bill's tenure.

I didn't realize the following until much later in my career. Bill signed all the fitness reports on the officers at the command. When I left he ranked me as number one of about 40 Commanders at the Hospital. He had a lot of impact on my career.

In the Fall of 1979 I went on a four-day fishing trip with a buddy of mine from UCSD whom I had done a lot of research with. When I got back my wife told me that BUMED

had called and wanted me to attend a meeting in Washington D.C. and that I had to leave for it the next day.

I asked, "What for?"

She said, "They're going to pick the residents for next year. They want you there to pick the hematology-oncology fellow for next year." So, I flew back and attended the meetings with the heads of the four pediatric departments with the residency training programs. After two or three days they sprung it on me: "The real reason we brought you here is we want you to take over the program at Oakland next year."

They wanted me to be the chairman of the department. I was a Commander at the time and they had three Captains who would be remaining on staff in the Oakland pediatric program.

I said, "I can't do that because there are three Captains up there and I'm just a Commander."

They said, "That doesn't matter."

I really didn't want to do that. I struggled with that decision a lot. I talked to my wife about it, and the chaplains at the Navy hospital that worked integrally with us in the hematology-oncology program. Rear Admiral Mel

Museles,[16] also a pediatrician and former director of the pediatric residency programs at both Portsmouth and Bethesda talked to me. He offered good counsel. He pushed me to go to Oakland[17] because the program there was in a lot of trouble. It was on probation and residents weren't doing well on the in-training exams. He said, "Look, Harold, the Navy's been really good to you and you've gotten to do a lot of research and got yourself established in the field; everybody knows who you are. It's time you pay back." He said, "Paybacks are hell, but the Navy needs you to do this now. He said, "I want you to look around at all your colleagues and you decide which one of those guys you want to work for in the future. Or, do you want them to work for you?" That got my attention. I looked around and I thought there are not many of these guys that I would want to work for. I would want them working for me because I have different ideas, like taking care of kids at home instead of in the hospital.

[16] RADM Melvin Museles, MC, USN (1929-2007).During his 30-year career in the Navy, Admiral Museles served as Chief of Pediatrics, Naval Hospital Portsmouth, VA; Chief of Pediatrics, National Naval Medical Center, Bethesda; Pediatrician to the White House; the Bureau of Medicine and Surgery (BUMED); and Commanding Officer, Naval Hospital Jacksonville, Fl. He retired from the Navy in 1982.

[17] VADM Koenig served as Chief of Pediatrics, Naval Hospital Oakland, CA from 1980 to 1983. In 1983, he was selected to be Director of Medical Service at Oakland, a position he would serve in through 1984.

I had championed some big changes in pediatrics at Balboa.[18] I transformed the pediatric acute care clinic from a walk-in hellhole where every day about 200 people would show up with their sick kids in tow to be seen without an appointment to a same-day telephone appointment system. Nobody had done that at any place in the military before.

I had a lot of ideas about how to make things better for the patient. I always put the patient first, the doctors second and management third. That was the way I looked at it.

I went to Oakland. When I got there I found out the residents weren't working very hard. They sometimes had morning teaching conferences, but more often they didn't; and they hadn't had a patient on the ward for two weeks. They were sending all the patients requiring hospitalization to Oakland Children's or University of California, San Francisco, because they didn't want to take care of them. It was a mess. I said, "It's over. No patient gets transferred without being presented to me and my being convinced the kid can't be safely cared for here." In a few weeks we had the census on our pediatric ward up to 20 and

[18] Naval Hospital San Diego, CA is informally referred to as "Balboa" on account of its proximity to Balboa Park in San Diego.

we didn't miss having another morning teaching conference, including Saturdays.

I also shut the door on the drug detail men — the baby formula and disposable diaper guys. They would come in every Thursday morning and the staff would shut the clinic, and any patients who showed up the nurses would send to the Emergency Room. The detail men would bring jelly donuts and coffee and the staff would sit around and eat, read the newspaper and chat with them. I made the nurses get rid of the baby formula gift packs the detail men brought in for new moms. We were trying to get women to breast feed, for good reason, but every mother that would leave the hospital with a case of ready-to-feed baby formula was getting a different message. I did a lot of things like that. I didn't make many friends doing that, as you can imagine. But I really got people to focus on what they were doing.

After three years there, the Navy decided to reorganize how hospitals were run, and decided they were going have directors for medical services, surgical services, nursing services, ancillary service and administrative services. I was told, "We want you to be director of medical services." I thought that should be the head of internal medicine.

I said, "No thanks."

I got that wrong, again.

For my last year at Oakland, I had oversight for general medicine, the emergency room, internal medicine, and pediatrics. I had absolutely no desire to move forward in administration. One day I was called to the CO's office, and when I got there he said to me, "Congratulations. You're going to be an executive officer."

I said, "Nobody asked me if I wanted to do that."

He said, "You're going to a hospital that begins with a 'P.'"

I'm thinking, Philippines, Philadelphia, Pendleton, Pensacola. It was Portsmouth, the second largest Navy hospital, San Diego being the largest. So, I packed up the family and we went to Portsmouth planning be there for two years.

I reported in to the CO, John Rizzi.[19] John had previously been the CO at Camp Lejeune, and then moved up to Portsmouth. Everybody expected John to make flag that year. Even John told me, "I think I'm going to make flag

[19] CAPT John Rizzi, MC, USN (1929-) served 28 years in the Navy (1958-1986). Rizzi served as Commanding Officer of Naval Hospital Camp Lejeune, NC (1981-1983) prior to becoming as Commanding Officer of NMC Portsmouth (1986-1986).

this year." John never made flag. But that first day he told me, "You're going to be here for two years." Four days later he called me back in his office and said, "I got a call from COMNAVMEDCOM, they told me to tell you not to unpack all your boxes."

I asked, "Why?"

He said, "You're going to Camp Lejeune next year as the CO because the commanding officer there wants to retire. They think you're ready."

After a few months they sent me to D.C. to be on a Medical Corps Captain promotion selection board. Selection boards always have a minority member and a female, and I'm not one of either of those. There was a bunch of old snarling, senior captains, a Rear Admiral who was Board President - and me. I was pretty junior for this sort of additional duty.

A month or so later they sent me to DC again to the Inter-agency Health Care Institute. This was a program at George Washington University where you met for a couple of weeks with contemporaries from the other military services and the Public Health Service. It's really a great program. They had a standing rule that you could not be

interrupted during any of the sessions for phone calls or messages unless it was an absolute emergency. Messages would be collected and distributed during the breaks. Then you could go put your quarter in a pay phone and make your call. (*We didn't have cell phones, then*). In class a clerk came in with a government standard Federal Yellow Message Form and handed it to me that read, "Call BUMED immediately." I'm thinking something happened with one of the kids or my wife, and so I go out and called the number and it was the Deputy COMNAVMEDCOM, RDML JJ Quinn,[20] who said, "Harold, congratulations, you're going to be the new CO at Bethesda."

I said, "What?"

He repeated, "Congratulations and good luck." Click.

The next day I got another yellow message form,and it said, "Call the Deputy COMNAVMEDCOM again, right away." So I called and he said, "Your orders to Bethesda have been cancelled."

I breathed a great sigh of relief and said "Thank you God."

[20] RDML James J. Quinn, MC, USN. Prior to this assignment Admiral Quinn had served as the Commander of Naval Hospital Bethesda, MD (1982-1983).

Then he said, "That's the good news." The bad news is "you're going to San Diego."[21]

I said, "As what? Am I going back to be a pediatric-hematologist again?"

He said, "No, as CO of the hospital." I'd been away from the hospital for five years and I left as a Commander division head, and now I'm going back as the CO, younger than, almost every other Captain in the command. Then he said, "The hospital got a provisional certification (which means it barely passed) its recent JCAH inspection. JCAH wants to come back next year. We told them we would replace the CO and they said in that case they'll delay their re-visit until you've had a year to clean the place up. Good Luck."

Q: No pressure at all.

A: I asked, "How do I get out of this?"

Q: He said, "You can't."

(There is a whole lot more to this part of the story than I have related here, including private one-on-one meetings with the Navy SG, the Commander Naval Medical Command and

[21] VADM Koenig served as the Commanding Officer, Naval Hospital, San Diego, CA from 1985-1987.

his Deputy and the IG. I don't need to drag a lot of this stuff out and put it in this record.)

So, as a family we've gone from San Diego to Oakland to Portsmouth and back to San Diego in five years. When I got to San Diego they were two and a half years away from moving to the new hospital[22] so we were trying to keep the old place going with Band-Aids, bubblegum, rubber bands and whatever else we could find, because it didn't make good economic sense to make investments in the old one.

Things were every bit as bad as the Navy leaders told me they were. It was awful.

Several of the GME programs were on probation. The Deputy COMNAVEMEDCOM had told me, "Your first job is to fire the chief of surgery because he's been in the job for two years and it's a disaster." The CO I was to relieve had been given these same orders, but failed to act.

I discussed this with the Executive Officer, Captain Fred Sanford[23] before the Change of Command Ceremony. He knew of this and said he would take care of it right after

[22] Naval Hospital San Diego reopened at its new location in January 1988.

[23] RADM Fred Sanford, MC, USN. Radiologist who spent 31-years in the Navy. Sanford's tours included XO, NH San Diego, CO, NH Newport and NMC Oakland, Medical Officer of the Marine Corps and Medical IG.

the ceremony. By the time I got into the office from the reception Fred had called the Chief of Surgery to his office and handed him his orders to Camp Pendleton as a staff Surgeon. I then named Captain William Rowley,[24] a vascular surgeon, Chief of Surgery. My tour started on that high note and went downhill from there.

Here's a high level digest of my first week as CO:

The hospital was delivering 450 to 500 babies a month, with a staff of seven obstetricians and nine residents. There was hardly any staff supervision for docs in training. The maternal morbidity and mortality rate was off the charts. They had ten maternal deaths in the previous year and one more the first week I was there. I immediately cut our delivery rate to 150/month, sending the rest out on CHAMPUS. That was a popular move with the expectant mom's and the community physicians. The rest of the time I was there we didn't have another maternal death or any other obstetrical horror stories. Three years later the *L.A. Times* ran a front-page article about the most dangerous hospitals for maternity care in Southern California based on data for 1988-89. They also mentioned the safest. The

[24] RADM William Rowley, MC, USN. Vascular surgeon who spent 29 years in the Navy. Rowley's tours included Deputy Commander, NNMC, MD, and CO, NMC Portsmouth, VA and NH Camp Pendleton.

Navy Hospital San Diego was listed as one of the two safest. Thankfully they had not looked at data from a year earlier.

An emergency medicine residency had been started the year before I got there. They did not have an RN in the emergency room except on the day shift Monday through Friday. They had Hospital Apprentice Corpsmen screening patients. A woman sat in the waiting room for four hours with severe chest pain. She was having a heart attack. She died in that chair. I closed one of our four internal medicine wards and transferred the nursing and Corpsmen staff to the emergency room. We had no more people die waiting to be seen during my tenure.

An over-worked corpsman on our third floor high-risk psychiatry ward failed to lock a door. A sailor on suicide watch spotted that and went out the door to the balcony and jumped to his death on the cement courtyard below. I asked Captain Richard Ridenour,[25] a psychiatrist and our Director of Ancillary Services for recommendations to prevent a further occurrence like this. He said it was a matter of having adequate staff numbers, so I moved more corpsmen

[25] RADM Richard Ridenour, MC, USN. Psychiatrist who spent 25 years on active duty and known as one of the originators of the SPRINT (Special Psychiatric Rapid Intervention Team). His duty stations include Commander, NNMC, Bethesda, MD, the Medical Officer of the Marine Corps, and Deputy Surgeon General.

onto that unit. We didn't have any more patients commit suicide on our psychiatry ward.

This was my "welcome aboard week."

We were overwhelmed with patients. There were so many people eligible for care there with the huge retiree population. People did not understand the difference between the words "eligible" and "entitled" - they thought they were synonyms. They aren't. I told retirees, "Look, it says right on the back of your ID card that we can do this if the resources are available." We just can't do all of everything. For example we can't give every retiree an annual eye exam. We simply don't have the resources; we were overwhelmed in most departments.

I was asked to present a seminar for retirees at the Naval Training Center. They had an auditorium that sat 2,000 people. I was asked to tell people what we could and could not do.

On the appointed night Deena and I headed to the Naval Training Center (NTC). We got on Barnett Avenue, one of the streets leading into the Center and there was a massive traffic jam. Shores Patrol (SP) were trying to direct

traffic and the city cops were showing up. I got up to one of the SP and asked, "What's going on here?"

He said, "Some Navy doctor is giving a talk tonight on healthcare availability at the Navy hospital."

I said, "That's me."

He said, "Oh, we better get you in there."

I go in and the place is packed. There were people sitting in the aisles, the fire marshal would have a fit. I told them the truth, "This is what we can do. And this is all we can do. And it's not right for us to try and do more for you when we're not going to be able to do it right. Seems as though no one had ever told them that before.

Knowing I had to get the command ready for a JCAH re-visit in 12 months, I called the head of credentialing for the hospital to my office and asked, "How many staff doctors do we have?" She did not know. I said, "Give me a guess." She guessed and was off by a factor of 2. She resigned later that day.

I asked the head of graduate medical education "How many doctors in training do we have at this hospital?" She did not know. We fixed that by putting some enlisted staff in to help her.

I checked on the medical readiness of our staff, the people who would have to deploy on the hospital ships and the fleet hospitals. We had people that had been at the hospital 20 years and had never had a physical exam, a dental check-up and there were no immunization records. They couldn't begin to meet the medical readiness requirements.

AS: These were active duty?

A: Yes, Navy Captains.

DG: Did the Navy have any form of IG inspections at the hospitals at that time?

A: They did, and they didn't look at this kind of stuff. I surfaced this on arriving there.

I had been there for 11 years before as a resident, fellow and staff physician, but I was off in my little corner of the hospital doing pediatric hematology-oncology and clinical research. I wasn't paying attention to all this other stuff.

The first week I was there I said, "A hospital should not be selling cigarettes to patients." We had cigarette vending machines on the wards. For a quarter a patient could get a pack of any of twenty brands on every ward

except the pediatric ward. Even the OB post-partum ward had cigarette machines. I had the Command Master Chief form a working party and remove all the cigarette machines. We had a Navy Exchange on base, and I called the Navy Exchange officer and told him to remove all the tobacco products - smokeless, cigarettes, cigars, pipe-tobacco, everything. I told him to have it all gone by the end of the week. The head of the Navy supply system came to my office and told me I couldn't do this, and I told him, "Yes, I can and I did, and we're not going to sell them here anymore." And I made it stick. We banned all smoking indoors and provided designated outdoor smoking areas.

(A couple of years later, when Jim Zimble[26] was the SG, and I was a Flag Select Jim assigned me to be on a smoking planning group with a couple of members of Congress and some physicians from the NIH. We met in Houston for two days and put together a national plan to decrease smoking. A major portion of that plan was to eliminate smoking on airlines. What we came up with was if a flight was scheduled for less than one hour there would be no smoking, then after a year it went to less than two hours, then less

[26] VADM James Zimble (1933-2011), Surgeon General of the Navy, 1987-1991

than three hours, etc. This was so popular with the flying public it was accelerated and smoking stopped on all U.S. airlines in just a couple of years. Later when I became a Deputy Assistant Secretary of Defense, we did the same thing in the Pentagon and all military hospitals and it soon was banned in all federal buildings.)

Having been a pediatric hematologist-oncologist, I had cared for many boys with Hemophilia. (*It's an X-linked recessive disorder, which means it only affects males; females are asymptomatic carriers*). These boys all received multiple transfusions of plasma concentrates when they had a bleeding episode. When I returned to San Diego every one of them had died from a "new" disease. We soon came to know this disease as AIDS, caused by the Human Immunodeficiency Virus (HIV).

Many people were dying of AIDS because they had received contaminated blood administered before we began testing the blood supply for the presence of this virus, or they acquired it by using contaminated needles to inject street drugs intravenously or they contracted it from having sex with an infected partner. One patient I remember well, Mr. Martinez, had run the mailroom the entire eleven years I had been there during my first tour.

He was a WW II Vet and had served with an uncle of my father, Captain Fillmore Koenig. We had become good friends. Soon after I returned Mr. Martinez had cardiac by-pass surgery. He came through the surgery fine, but he soon became ill and was dead within 6 weeks. He had received blood during the procedure that was eventually found to contain HIV. He died of AIDS.

There were close to 3,000 active duty staff at the hospital and Corps School. Every one of them had to be tested for HIV. Since there were so many to test, testing was done in weekly batches. Navy policy was that positive reports had to be delivered sealed to the CO only and the CO had to personally and privately notify the individuals that they were positive. Then the person would be processed for discharge. No exceptions were allowed.

There was a superb Lieutenant male nurse in our ICU for whom I had written a letter of recommendation to go into the Navy's Nurse Anesthetist training program, and he had been accepted. The day he detached he came to my office for his departure call and to thank me. Within one hour of his leaving my office the weekly HIV positive report came in, he was one of the positives on the list. I asked my secretary, Donna Mackenzie, to see if she could

find him. She did, and when he came to my office he said, "Skipper, you don't have to tell me, I know." I thought so highly of this officer I personally called COMNAVMEDCOM and requested a waiver. The answer, "no exceptions." Donna kept track of this fellow and some years later told me he had succumbed to AIDS. I saw way too many cases like this.

Let me relate here an important moment in my career. I was in my office on the phone with the Commander, Naval Medical Command,[27] RADM Joe Cassells.[28] Joe had been the XO at San Diego when I was there and Bill Cox was CO, so we knew each other well. While talking with him I looked at my wall, and saw my commissioning certificate. I realized that this was my 20th active duty anniversary day. I said, "Joe, guess what? I've got tenure, I'm good to go." I really intended to retire.

I won't go into further details. Suffice it to say that with a dedicated staff and support from Washington we

[27] From 1 Oct 1982 to (officially) 1 Oct 1989 BUMED was deactivated and replaced by the "Naval Medical Command" (COMNAVMEDCOM). With the deactivation of BUMED, the Chief of BUMED ceased to exist. The Surgeon General moved to the Pentagon and joined the OPNAV staff. The direct line of authority to the Secretary of the Navy that had existed since 1842 had been broken. The establishment of this new command structure arguably introduced many ambiguities.

[28] RADM Joseph Cassells, MC, USN (1933-2003). Cassells served as Deputy Special Assistant to the Surgeon General for Education and Training (1975-1977) and later as Special Assistant to the Surgeon General for Professional Matters (1977-1978).

were able to turn the command around and a year after I arrived, the JCAH came back, as promised, and we got a score of 99/100.

There were some unhappy campers in San Diego, mostly senior people who had been there for many years whose personal fiefdoms had been brought down by some of my actions. Some reminded me of my Senior Medical Officer in Sasebo that I vowed to never be like – ROAD officers. With the help of COMNAVNMEDCOM (BUMED today) and NMPC(BUPERS today) I helped those people find a new life outside the Navy. Later on a few of those officers tried to scuttle my career after I had moved on. It didn't work.

Here's a short story about how your past follows you. A current neighbor, good friend and fishing buddy is a local probate attorney. This week(late in 2015), he told me he has a new client, a retired Navy doctor, who says he knew me and that I had once issued and order that no one was to ever call me "Koenig the Barbarian." I don't remember the officer or ever saying anything like that, but it makes a good story.

San Diego was an incredible pressure cooker for all the reasons that I've given and many more. It was just

incredible. Horrible. I hope no hospital commander ever has to go through anything like that again.

A few months before finishing my 2nd year in command I got a phone call from the Head of Medical Department Detailing at NMPC, telling me, "You're moving. You've got orders." This I wasn't expecting. I thought I was going to be there the normal three years for a command tour and execute the move into the new hospital. I asked, "What about the new hospital?"

He responded, "We'll just send the new guy out. You've got it all planned for anyway, so he just has to follow the script." Another thing that I had done, and hardly anybody knows this, was the hospital ships were built here in San Diego while I was CO, and I had an ancillary job to visit with the construction sites every few months.[29] I would walk through the *Coronado*-class tanker holds that the hospitals were being constructed in and find out what was going right and what was going wrong.

The third thing I had to do was stand up the Fleet Hospital and conduct an operational test and evaluation of it at Camp Pendleton; that ate up a one month block of my

[29] Hospital ships USNS *Mercy* (T-AH-19) and USNS *Comfort* (T-AH-20) were constructed in San Diego and launched in 1986 and 1987, respectively.

time. So, after accomplishing all that, I thought, well, the least they can do is leave me here for the opening of the hospital and then I'll retire, right?

No, wrong again.

The detailer told me I was going to Bethesda to be the CO of HSETC - Health Science Education & Training Command,[30]

I did get to do one nice thing before I left. We had a "stepping of the mast" ceremony at the new hospital. That means we put some silver in the footing for the new Flag Pole. Tradition has it that this has been done on naval vessels for millennia, the reason was to have some silver available to grease the palms of the guards and be assured good treatment in case the vessel had to cross the River Styx. So I, along with RADM Jim Sears,[31] **went to the ceremony and each tossed a silver dollar into the hole before the mast was stepped. Mine was a silver dollar my Dad had given me.**

[30] HSETC (Health Sciences Education and Training Command), Bethesda, MD—a vestige of the Navy Medical School, the command operated as HSETC from 1973 to 1995 when it was renamed the Naval School of Health Sciences (NSHS). In 2002, it was redubbed the Naval Medical and Education Training Command (NMETC). VADM Koenig served as CO of HSETC from 1987 to 1988.

[31] RADM James Sears, MC, USN. Psychiatrist who spent 25 years in the Navy. His tours included Commander, Naval Medical Command. Along with RADM Ridenour Sears was one of the originators of the SPRINT program. In his post-Navy career, Sears serves as the Executive Director for Tri-Care Activity, Falls Church, VA.

We packed up the family again, this time minus one; our oldest stayed behind to continue school in the NROTC program at the University of San Diego, and headed east. Now we'd gone from San Diego to Oakland, to Portsmouth, to San Diego, to Bethesda in seven years.

I was at HSETC for 11 months. That was a great tour. I was out of the pressure cooker. One memorable event from HSETC was a visit just before I was to detach by a Senior Medical Student at USUHS, an Ensign Steve Schallhorn. He was graduating in the top 5% of his class and wanted to go into Ophthalmology right after doing an internship. This was unheard of in the Navy. All people going into ophthalmology residencies did a utilization tour first, usually Flight Surgery. He thought he should be exempted from that requirement because he had gone into the Navy in 1977 after graduating from college and become a Naval Aviator, flying F-14's. He had excelled at this and become a Top Gun instructor, receiving many awards along the way. He had also been deep selected for promotion to CDR just before going off to USUHS and becoming an Ensign, again. It made sense to me that he should be exempted, so I became his champion and he went directly into an ophthalmology

residency after internship. I'll come back to Steve Schallhorn later on.

The hardest job I ever had in the Navy was being CO of the Navy Hospital, San Diego, though what's coming in the 1990-1994 period was a very close second.Hang on...

While at HSETC I planned to come back to San Diego for the commissioning of the new hospital on Jan 30, 1988. The afternoon before Deena and I were about to leave for National Airport to head West for the ceremony I got a phone call from Jim Sears. He told me he had waited five minutes after the announcement was made to give Jim Zimble a chance to call me first, but he was stuck in a meeting. The call was to congratulate me on being selected for Flag. Jim came called a few minutes later. Deena and I had to leave for the airport then, so my middle son, who had gotten home from school, answered the rest of the calls.

Then my whole world changed because Jim Zimble started assigning me to study groups and panels, and I spent more time away than I did in my office at HSETC. After 11 months they moved me to OP-093.

There was a lot of turmoil in Navy Medicine at that time, and I was in my new job in OP-093 for only three months, and then there were many changes. The CO at the National Naval Medical Center, Bethesda, and the National Capitol Regional Commander were relieved. Don Hagen,[32] who was Medical Operations at COMNAVMEDCOM (MED-03), moved to Bethesda and took over the hospital and the regional command. That left a gaping hole in medical OPS at COMNAVMEDCOM. I got tagged with relieving Don Hagen. I worked for Jim Sears at COMMNAVMEDCOM until it was phased out and became BUMED again.

BUMED-03 was a fascinating tour. First of all, I had highly-qualified people, the best of the best that the Navy had. There were a few exceptions that I soon replaced. That was my first tour at headquarters, and I learned to understand how it operated, I was in the middle of everything.

Jim Zimble is another Person who had a lot of impact on my career. Some of it initially was circumstantial but later on, it was intentional. Recall, I mentioned that there were some senior Captains at San Diego who weren't pleased with me. They got to Jim who I had never known. I

[32] VADM Donald Hagen, Surgeon General of the Navy, 1991-1995

recall something he said to me at the time my selection to Flag was announced. He said, you're still pretty hot and I'm going to have to cool you off for a while. While working for him at BUMED for two years he sent me on several trips to represent him. He said the travel was too hard for him to go through, but that was fine with me, I enjoyed it and learned a lot.

After we had worked together for a year he said to me, "There's an intensive two week course at Harvard in July at the Kennedy School.[33] We've never sent anybody from the Medical Department to it but Vice Admiral Mike Boorda,[34] the Chief of Navy Personnel at that time, said he would like you to go."

That course was a career changer because I was with all really smart guys - Army, Navy, Marine Corps, Air Force, State Department, and Academics. The Dean of the Kennedy School taught the course. He was in our classroom every day. I really got to understand what was happening on a much larger scale. One of the takeaway lessons from that course was the Dean saying that the Soviet Union is going

[33] Kennedy School, aka "The John F. Kennedy School of Government" at Harvard University is a public policy and public administration school offering master's degrees in public policy, public administration and international development.

[34] ADM Jeremy Michael Boorda (1939-1996), USN, Chief of Naval Operations, 1994-1996. Boorda was the only enlisted sailor to advance through the ranks to CNO. He committed suicide on 16 May 1996.

to collapse, soon. He wasn't sure of a date, but it would be sometime in the next three years. As a matter of fact, a few months later the Berlin Wall came down and a year and a half later the Soviet Union ceased to exist.

I came back to Washington from this course on a military hop with a couple of line guys who were also in the course. Deena picked me up at Andrews AFB and we stopped at BUMED to check my mail. VADM Zimble's Chief of Staff saw me and said, "Go down to the bosses office. He wants to talk to you."

So I go and he asked, "Well, how was the course?"

I said, "It was great. I really learned a lot."

He said, "Now Admiral Boorda wants you to go to CAPSTONE[35] in October. We've never sent a medical department person to this before either, so you will be the test case. You've already been nominated and have a billet." He went on, "The reason we're doing this is you are going to Europe next summer to be the CINCUSNAVEUR[36] surgeon. Mike Boorda is

[35] Capstone— a joint service professional military education courses for newly promoted brigadier generals and rear admirals serving in the United States military. The National Defense University conducts the CAPSTONE course at Fort McNair in Washington, DC. The course's objective is to ensure senior military leaders understand how military forces and other elements of national power are integrated and used to support national military strategies, and how joint, interagency, and multinational operations support strategic national objectives. (Source: /www.ndu.edu/CAPSTONE).

[36] CINCUSNAVEUR (Commander in Chief, U.S. Navy Europe). Now known as Commander, U.S. Naval Forces Europe (COMUSNAVEUR).

going to get his fourth star and go there to be CINCUSNAVEUR." Given that the Cold War was still Hot, this promised to be a good assignment.

I went through Capstone and traveled all over Europe. I was in Berlin on the first Saturday, Sunday, and Monday of November 1989 and on Tuesday I went to Norway and then to London. Thursday, I flew back to Washington and while I was in the air the Berlin Wall opened. So I had been there just before that happened. Now that assignment to CINCUSNAVEUR didn't look so hot any more. Europe was safe and our involvement in the region was going to rapidly decline.

A month after Capstone I was sent to Germany for a week, for another NATO meeting. This one was to discuss the ramping down in Europe after the opening of the Berlin Wall. The world was already beginning to change fast.

Because Deena and I were going to England and there wasn't military housing in the city, the Navy gave me a week's time for us to go there and house-hunt. Before going I contacted CINCUSNAVEUR headquarters about getting hotel reservations and a real estate agent to show us around. I thought they'd put us up in a hotel. Instead they connected me to the Chief of Staff, who turned out to

be now Captain Hank Dalton, father of my late patient, Megan, who died with the liver tumor. He and his wife, Penny, were planning to come to the States in early February, for their son's wedding. They suggested we plan to come during that week and stay in their house. We did! (*BTW, some years earlier I had written a letter of recommendation for their son that helped him get into the Naval Academy*.)

As spring of 1990 arrived I began to wind things up at MED-03.[37]

Then Jim Zimble had one more trip for me before I detached--to Norway for a Northern NATO Medical conference. This was mid-April, 1990. It would only take four or five days, but he said, "It's really important that you go to this because in two months you're going to be in the job over there." They only had this meeting every other year. "So it's a chance to meet all your counterparts, all the Northern NATO medical guys."

Just a few days before I was to go to Norway a Public Heath Service Rear Admiral, Ed Martin,[38] came to my office

[37] Healthcare Operations (Med-03), BUMED, Washington, DC

[38] RADM Edward M. Martin, PHS. A 23-year veteran of the Public Health Service, Martin served as Chief of Staff for C. Everett Koop. Martin served two tours as Acting Assistant Secretary of Defense (Health Affairs) in 1993-1994 and 1997-1998.

to make a courtesy call, a scheduled 15-minute visit. He had been the Chief of Staff to C. Everett Koop[39] when he was the PHS SG during the Reagan Administration. Ed had been re-assigned to the Pentagon to the Office of the Assistant Secretary of Defense (Heath Affairs). The 15-minute visit wound up lasting a couple of hours. We found a lot of common ground to talk about.

The next day I got a call asking me to come to Health Affairs to meet the new Assistant Secretary of Defense (Health Affairs), Dr. Enrique Mendez.[40] Ed Martin had suggested he and I meet before I left for Norway. We had a nice, cordial visit.

The next day I flew to Trondheim, Norway for the Northern NATO Medical meeting. While sitting in the conference room with the Norwegians, Brits, Germans and others and heroically fighting jet lag, an Army Colonel tapped me on the shoulder, and says, "There is an Admiral Boorda holding on the telephone for you."

I go to the phone and he says, "Harold, you may as well come back home. Your orders have been canceled."

[39] VADM C. Everett Koop, PHS, Surgeon General fo the United States, 1982-1989.
[40] Dr. Enrique Mendez, Assistant Secretary of Defense (Health Affairs), 1990-1993.

He said, you're going to go be a Deputy Assistant Secretary of Defense in Health Affairs."

I said, "You've got to be kidding me." "Whom do I talk to get out of this?"

He said, "Talk to the guy who approved your orders."

I asked, "Who's that?"'

He said, "Dick Cheney."

What had happened was the new Assistant Secretary of Defense (Health Affairs), Enrique Mendez, had said he wanted a military medical corps officer as one of his five deputy assistants (DASD's), who would be the OPS Deputy. Each of the services had been tasked to nominate a flag officer doctor, so Jim Zimble put my name in but didn't tell me. It turns out Dr. Mendez had listened to Ed Martin about his meeting with me and then had me come over to check me out. That was my interview for the job in Health Affairs. No one had bothered to tell me. Dr. Mendez told Dick Cheney. "That's the guy I want."

Cheney said, "So be it."

So I asked Admiral Boorda, "When do I report?"

He said, "Today's Thursday, you probably won't be able to get home until late Friday, so how about Monday?"

Monday morning I reported and I was there for four years.[41] That was almost as big a challenge as San Diego. It was challenging because I had so much to learn. I had to learn about the Army and the Air Force and their medical departments and how they were organized, and what was driving them to do things the way they were. It was hard to assimilate all that information quickly.

The first thing I had to do was select a Deputy. I interviewed a number of outstanding candidates and wound up selecting Patty Watson (now Patty Lewis). She had spent a number of years on Capitol Hill working on the Senate Armed Services Committee, and I felt I really needed someone with a good background in how the legislative branch worked. Much of what I would be doing in this assignment involved interaction with Congress, both staff and members. Patty guided me through that maze all four years.

My responsibilities included all military medical construction of hospitals, clinics and medical research units worldwide - Army, Navy, Air Force, and Marine Corps.

[41] VADM Koenig served as Deputy Assistant Secretary of Defense for Health Services Operations, Wash., D.C. from 1991 to 1994

I had to sign off on every one of those contracts and that was high risk, some of the contracts were in the multiple hundreds of millions of dollars.

Two months after I got there Dr. Mendez fired the SES Officer who was in charge of CHCS.[42] At that point CHCS had been deployed to two Alpha and 12 Beta sites. Then he assigned CHCS to me. My job was to get it to the point where the Defense CIO and the GAO would sign off on it so we could deploy it worldwide, which was accomplished because of the skills of a lot of people led by two SES officers, Diana Tabler and Al Andreoni, and Navy Captain Paul Tibbits. That was a huge project, costing about $2 Billion to complete.

I had other things that occupied a lot of my time, including all constituent mail to members of Congress complaining about access to care, or something that had to do with medical care, they'd send it to the services, and the services would send it to Health Affairs. I had responsibility for drafting the response to those letters, there were several of them every day.

[42] The Composite Health Care System (CHCS) allows clinicians to electronically perform patient appointment processes and scheduling, order laboratory tests, authorize radiology procedures and prescribe medications.

I was assigned a collateral duty to suggest new ways to manage the service healthcare budgets. The Army, the Navy, and the Air Force had their own budgets for their medical programs, including to pay their CHAMPUS[43] Bills. There was always a huge problem with CHAMPUS payments. The services would take the CHAMPUS money at the beginning of the year and spend it on other things, and then at the end of the year go back to congress and ask for a supplemental appropriation so they could pay the CHAMPUS Bill. Congress was fed up with this management approach. Because of this conundrum, I was one of two people from Health Affairs assigned to the working group that developed the Defense Health Program (DHP).

In 1991 I had a real scare. I developed bladder cancer. I went through treatment at Bethesda. It was not pleasant, but it seemed to work. I missed about a month of work.

I was in Health Affairs during the transition between Bush 41 and Clinton. At noon on Inauguration Day, all of

[43] CHAMPUS (Civilian Health and Medical Program of the Uniformed Services) was a Congressionally-directed DoD medical program that started in 1966 for military dependents, retirees, retirees' dependents, and survivors. It was superseded in 1994 by Tricare.

Bush's political appointees picked up their attaché cases and walked out of the building. I was in a position that is normally filled by a civilian political appointee, but when a military person was assigned as a DASD, which was rare, you had to stay. The only people left at the top in Health Affairs were Ed Martin, Marty Kapert, and myself. Marty was the head of CHAMPUS. We got together with Karen Heath, one of the senior staff members on the House Armed Services Committee and put together a program to replace CHAMPUS. That program eventually became known as TriCare.

As another ancillary responsibility, I was assigned the Physicians Pay Reform effort. We came up with the system that is used to this day for providing bonuses to medical department officers, not just doctors, but dentists and allied scientists as well.

I did an incredible amount of travel as a DASD. I probably went to Europe four times a year, Hawaii a couple of times and Asia once.

I was also the medical guy for BRAC. We had to do the medical impact studies for all the bases being considered for closure by the BRAC commission. There were BRAC's every other year, in non-election years of course, so I did two of them.

AS: So we're looking at what? Philadelphia, Oakland. Was Orlando on that list?

A: Yes. I traveled with members of Congress to the medical facilities in their districts that were on the list. I covered Navy, Army, and Air Force, it didn't matter what service it was. I went to installations with thousands of retirees living around them and dealt with their questions and well-founded anxiety. I testified before the BRAC commission and C-SPAN ran a segment on it dozens of times.

One problem Congress had not anticipated when they started the BRAC process was what would happen to retirees who were being served by military medical facilities, who because they thought it would always be there for them, had not taken Medicare Part B. People could sign up for Part B anytime after they became Medicare eligible, but for every year they delayed after turning 65, their Medicare B premium would increase by 10%. That could turn into a lot of money for a retiree with a limited income. I pointed this out to the congressmen who had bases being considered for closure in their district. They had a simple solution for that; just pass a bill forgiving the penalty for these people. That sounded simple enough but it took a lot of effort to get it accomplished.

I went back to BUMED in June 1994 as Deputy SG and Chief of the Medical Corps for about a year.[44] Don Hagen was in his last year as SG. He spent a lot of the year burning off excess leave, job hunting, and traveling one more time to Europe and Asia, so basically I ran BUMED most of the year I was deputy.

I was scheduled to become SG on June 29, 1995. I had known this for several months but it had not been announced because Don Hagen wanted to announce it at the Navy Medical Birthday Ball in April. Deena and I decided to sponsor a table at that dinner and invite Navy Senior Medical students at USUHS to be our guests and sit with us. One of those students eventually became my Urologist, (now Captain Don Crain), now the Department Chairman in San Diego. The other became my Ophthalmologist (now Captain Kim Davis). She's now the XO at the clinic at Pearl Harbor.

Here's how I picked my Chief of Staff and Aid.

Since we had known for some time I was going to be SG, Don Hagen suggested I should pick who I wanted to be my Chief of Staff and Aide. Picking the former was easy; I

[44] VADM Koenig served as Deputy Surgeon General from 1994 to 1995.

wanted someone with a strong background in finance that could help me keep the BUMED Comptroller under control. Unless you control them, Comptrollers will control you. If you plan to be the one in control you better know what you're doing. So I picked Captain David Fisher, MSC. He had a strong background in finance. He accepted and stayed with me my entire tenure. He was a rock.

Picking an Aide was a different challenge. Falling back on my Health Affairs experience, I knew I needed someone who knew his or her way around the legislative arena. The best candidate I felt was a Reserve Nurse Corps LCDR. That posed three challenges, first gender, second she was a Reserve officer, and third, she was Nurse Corps and traditionally a Medical Service Corps Officer filled this position.

To get advice on the gender issue I contacted my Plebe Summer Company Officer, Admiral Charles Larson, who had been recalled after retiring from his final assignment as CINCPAC, or as it is now known, PACOM. He was re-called to clean up a mess at the Naval Academy and was the only male Flag Officer with a woman as an Aide. He told me if I felt she was the best candidate, pick her, and deal with the other issues later.

I had my EA, CDR Dave Maloney call LCDR Tracy Malone[45] to my office. When she came in I asked her to sit down, I did not want her to fall down. I told her my plan and how'd we deal with the Reserve and Corps issues. She thought it over and said, okay! I've got a few Tracy stories to tell later on.

I became SG, and I suspect you have some questions about that.

AS: Admiral, can you talk about your four goals as Surgeon General and how they came about?

A: I thought four goals was the maximum I could accomplish in a tour as SG so I tried to encapsulate everything into them. "Taking healthcare to the deck plates" was to get people to understand that the closer they took care of patients to where they worked and lived, the better the results were going to be. This was an outgrowth from my early years when I was taking care of kids with cancer and leukemia as outpatients rather than as inpatients. The idea was similar to the mobile dental vans; they'd send the dental vans pier side and take care of the sailors on the

[45] CAPT Tracy Malone, NC, USN. A 26-year veteran of the Navy, CAPT Malone's career included tours with the White House Medical Unit, BUMED Legislative Affairs, and Tri-Care Management Activity. In 1995, Malone became the first woman and first nurse to serve as EA to the Surgeon General of the Navy.

ships to make sure their dental readiness was where it needed to be. One of the things we had learned in Navy medicine was that we lost more time at sea from dental emergencies than we did from medical health problems. We became very rigid about the state of a person's dental health. If they didn't meet our dental class one or two standards, they could not deploy. This requirement paid off in spades.

"Moving information not people" had to do with getting telemedicine into place. We had done some telemedicine with our forces in Bosnia. Don Hagen had gotten that started, but I thought, "Let's get it onboard the big ships, start out with the carriers." I got the CO of Bethesda, RADM Dick Ridenour, to find a couple of tech-smart officers to talk with me and see what we could come up with. One was a CDR, nuclear medicine doc, and the other a LCDR, a pediatrician with subspecialty training in developmental disorders; both had a strong interest in digital technology and what it could do for health care. They got telemedicine onto some of the carriers. The carriers started sending x-rays back to our Medical Centers for reading and then the results went right back to the ship. We gradually got that expanded to all the carriers and most of the big deck

amphibs and to some of our smaller, remote facilities. An x-ray would be taken and within minutes the deployed doc got the report. Sometimes they'd do a voice hookup and talk with the MedCen docs about the x-ray. The specialists ashore would show the deployed docs where the points of concern were.

The two docs that pulled this off were both USUHS graduates. The CDR Nuclear Med doc was Rich Bakalar who retired as a Captain and went on to be President of the American Telemedicine Association. The other, the pediatric subspecialist, is still on active duty; he is Vice Admiral Forrest Faison, now the Surgeon General.[46]

This telemedicine effort led me to a post-retirement activity that I would like to mention here. Just before I retired I was asked to attend a meeting of a group of forward-thinkers interested in telemedicine where I was introduced to Billy Amoss, the COO of the Rostropovich-Vishnevskaya Foundation. Mstislav Rostropovich[47] and his wife, Galina Vishnevskaya[48] had previously been exiled from the Soviet Union for dissident activity. They had come to

[46] VADM C. Forrest Faison, MC, USN, Surgeon General of the Navy, December 2015-Present
[47] Mstislav Rostropovich (1927-2007), Azerbajanian-born cellist and conductor
[48] Galina Vishnevskaya (1926-2012), Russian-born soprano who was married to Rostropovich from 1955 until his death in 2007.

America and he became the conductor of the National Symphony in Washington, a position he held for nearly 18 years. He was widely recognized as the finest cellist in the world and his wife had been the leading soprano in the Moscow State Opera. After arriving in America and getting established, he started a foundation to try and improve the health care of children in what later became known as the Former Soviet States. One project they were embarking on was a telemedicine link between the Children's Hospital in St. Petersburg and DC Children's in Washington. The goal was to help the doctors in St. Petersburg improve the care of children with cancer and leukemia. They found a two-for-one in me. I knew a little about telemedicine and was also a pediatric hematologist-oncologist. I was asked to join the board of the Rostropovich-Vishnevskaya Foundation.

I have been on the board since I retired. We have improved care for many children in several former Soviet States and expanded to the Palestinian Territories. We have provided immunization programs to over ten million children in these countries and several other programs as well. I have traveled to many of the places where we are providing help including St. Petersburg, Moscow, Baku, The West Bank, Israel and Jordan. In November of this year I

traveled to Tbilisi, Georgia where we have several projects underway, the most prominent a program screening newborns for critical congenital heart disease before they are discharged home after being born. We have already found a couple of dozen affected babies and had their defects corrected, perhaps preventing death in some cases had they left the hospital without it being discovered. So, my knowledge gained in the Navy has served me well in these humanitarian efforts.

Moving information not people involved moving medical records instead of or before the patient, so the receiving or consulting facility knew what to expect. If you have to move the patient, move the information ahead of the patient so the receiving facility can be ready to take care of them on arrival and they won't be duplicating effort. That used to aggravate me when people would repeat tests already done. The idea behind moving information and not people was to get them to understand that delay and repetition costs time and money.

"Making Tricare Work" came about because we were starting Tricare. I remember thinking, what are so hard about three choices? One is the benefit you've got now. The other two are free and a lot better than the former. It

cuts cost and it makes things better. But a lot of people, including very senior people, had trouble with that.

Marketing Tricare was going to be a huge challenge. Consultants told us it would take ten years to really get it accepted. I think we actually did it much faster. There are still issues that people complain about, but Tricare is considered to be the best federal health program there is. It's working very effectively and people are trying to make it even better.

The CNO after Mike Boorda, had a hard time understanding Tricare. He was a smart guy, but he had problems understanding when it came to healthcare. He called me in one day because a Rear Admiral had dropped dead in Hawaii running the physical fitness test. The dead Admiral was in his early 50's, and the CNO said, "How the hell can that happen? He had his physical a month ago and he had a normal EKG."

I said, "Admiral you don't understand, EKG's can't predict someone is going to have a heart attack. Stress tests are needed for that, and even they aren't fool proof. We shouldn't have 50-year-old admirals out running a mile and a half for time. We should stop that." They shouldn't do that until we're absolutely certain that their hearts

are okay. An EKG isn't enough of a test of that. He and I did not get along.

Here's a contrasting story about alcohol. This happened when I was SG and Mike Boorda was CNO. We were both distressed about the number of sailors and Marines we were losing to problems with alcohol. My oldest son was getting his wings as an NFO. I went to San Diego to attend the Squadron winging ceremony. I went to the Squadron CO and introduced myself and said, "After the promotion ceremony, I don't want to see anyone taking the wings off the newbies and dropping them in a pitcher of beer and not letting the guy put them back on until he's drunk down the whole pitcher." I said, "If I see that happen, I will report that to the CNO tomorrow morning and you will get a phone call you won't like." And I meant it. So he put the word out, don't do it and they didn't.

The next day, I was back in D.C., and I told Admiral Boorda about it. We were having a conference that morning with over 100 admirals. Admiral Boorda had me stand up at the beginning of that conference and tell that story to them. He said, "That's what I want you guys doing. I want you guys to really work hard at getting alcohol out of Navy ceremonies." Alcohol had been a big part of Navy ceremonies

for far too long. Ceremonies had become an excuse for some to get smashed.

Finally there was "Reengineering business processes." What I was trying to do was to get people to eliminate non-value added steps in their work process. Here's a great example: as we got CHCS up and running with appointment systems, I would go into a clinic and they'd have a green logbook. They'd take a ruler and draw vertical lines on a page creating columns, and then they'd write down the patient's name, social security number, contact information and why the patient was there. The Navy had been doing this for ever. Then they'd copy all that information into CHCS. I would ask, "Why are you doing all that work twice? Why don't you just do it once?" Some people got that and some didn't. We came up with a phrase, "No more green logbooks." Everywhere I'd go we looked for green logbooks. Force Master Chief, Mike Stewart,[49] would accompany me; his job was to look for green logbooks, and every one he'd see we'd pick up and leave with it.

I'll tell one more green logbook story. This involved Senator Joe Lieberman[50] from Connecticut. The submarine

[49] HMCM Michael "Mike" Stewart, USN, Force Master Chief Petty Officer of the Navy and Director of the Hospital Corps, 1994-1998.

[50] Joe Lieberman, Democrat later Independent Senator from Connecticut from 1989 to 2013.

training center was in his state, and during World War II, a lot of the sailors who went through sub training couldn't pass the diving chamber test because they couldn't decompress their ears. They'd rupture their eardrums. The reason was because their adenoids were so big. When you're a young adult or late adolescent, your adenoidal tissue is at its peak. The way the Navy dealt with those guys so they could decompress and pass the diving chamber test is they shrunk their adenoids with radium; they put a little probe with a dollop of Radium on the end back through their nostrils and they'd radiate their adenoidal tissue so it would shrink the lymphatic tissue.

Fast-forward 50 years, and some former sailors had developed head and neck cancer. Never mind the fact that almost all them were also heavy smokers. They'll blame it on the Navy so they can get compensation. I dealt with the Senator on this when I was at Health Affairs and then again when I was SG. We really worked to find these guys. We would find the WW II era green logbooks, and identify the last name, first initial, and a Navy ID number — this is before we used social security numbers for ID. We would see if they'd received radiation. Some got a little bit; some got a whole lot. The amount was determined by the length

of time the probe was left in place, nothing else. Fifty plus years later we would try to find these former sailors and find out what happened to them. We found a few. So, we finally thought we'd done it all, and Joe was happy we'd gotten that off the table and gotten a few guys compensated.

In the 1990's we closed the clinic in New London. A long closed closet was opened and there was another box of green logbooks. They called and asked, "What do you want us to do with them?"

I said, "Pack them up and ship them to me." I called up Senator Lieberman's office and said, "guess what we found?" I waited for the explosion; instead he said, "Thank you so much for being honest with me and bringing that to my attention right away." That was the end of it.

Ultimately, I picked those four goals because I wanted to take care of people as quickly and as efficiently as possible; minimize their downtime and their away-from-the-job time; move information not people so you're not duplicating efforts; help them understand Tricare; and reengineer our business practice — just look for redundancies and become more efficient.

Remember patient satisfaction surveys? I think they are still around, at great expense to the government, with little return of information to the deck plates. The CO at Millington, Tennessee, Mike Kilpatrick, came up with one of the best ideas I ever saw. It was nearly free and feedback was essentially immediate. Each patient was given a poker chip at his or her visit. The poker chips were coded for wherever the service was being provided. When they left they'd drop their poker chip into one of three buckets — "good," "average," and "lousy." He could determine which clinics were not working efficiently every day. That's an example of a CO who really used his imagination and went after ways to improve efficiency.

As SG I was also interested in harnessing technology to improve efficiency at BUMED. When I got back to BUMED in 1994 they were still using TRS-80s.[51] Everybody had his or her own computer with 5¼ floppy disks. They'd burn their document to a disk and along with a hard copy of the document they'd send it on to the next desk in the chop-chain. I thought this was a terrible waste of time, effort and resources. I got a contract and brought in brand new

[51] TRS-80s were desktop microcomputers manufactured by the Tandy Corporation

computers for everyone and installed a wide-area network. We installed the same version of Microsoft Office on all computers; we set up training classes for anyone who needed it before we turned the system on. Anybody that wanted help in how to use Microsoft Office could come learn it. We had a drop-dead date for implementation. One weekend we pulled out all the old computers and put in the new ones. On Monday morning we went to work, hardly a hiccup. I said this is how we're going to do business from now on guys. We're not walking paper work and floppy disks around the compound anymore. We send it digitally.

I got all my staff in the front office together, myself, my EA, my deputy EA, my Aide, my Flag Writer and half-dozen or so civilian clerical personnel. There was an IBM Selectric typewriter on a desk in the middle of the office. I asked, "What is this typewriter still doing here?" "One of the things we're trying to do is clean this old technology out; we need to get rid of all these old IBM Selectrics."

One of the most senior of all the secretaries piped up, "We need the typewriter to address envelopes."

I said, "No, you don't. We are going to have a tutorial on this at 1400 and I am going to do it. I will

show you all how to do envelopes using Microsoft Word." So at 1400 I sat down at the computer and did one. I turned around and looked and there were about 20 people watching me do this. Pictures were taken.

We rounded up all the old computers and typewriters and stored them in the basement of a building on the BUMED compound. A lot of these buildings were 100 years old or more, and one of them was on the slope of a hill. When you came in the front door, it was the middle floor, but you went down the hill, around the back of the building, and there was this big basement with a lot of windows in it; that's where we stashed all these old computers and IBM Selectrics. We had hundreds of them. One person who lived on the compound at that time was the Vice-Chief of Naval operations, a great guy named Admiral Joe Prueher[52] who went on to be CINCPAC, and then in retirement became the U.S. Ambassador to China. Joe came to my office one morning and said, "I was out walking around last night having my cigar " (*His wife wouldn't let him smoke cigars in the house or on the porch.*) "and I saw all these computers in that building down the hill. What are you doing with them?"

[52] ADM Joseph Prueher, USN, Vice Chief of Naval Operations, 1995-1996.

I said, "We're surveying them."

He asked, "Could I have them for BUPERS?" They were still working on IBM Selectrics, hunt and pecking out orders for hundreds of thousands of sailors all over the world. So all the old BUMED TRS-80s went to BUPERS, and they probably worked with them until they moved to Millington, Tennessee.

AS: Admiral, one of the hallmarks of your administration was "Frames of Choice." Could you tell us how that came to fruition?

A: That was an interesting program because it also involved Joe Prueher. I was in Joe's office and he told me his wife had mentioned, "Those glasses you make the sailors wear are terrible." He asked me, "Is there anything you can do about this?" I knew what I could do about it because when I was a DASD, the whole optometric program came under my directorate. There was a group of senior optometrists from the three services who were supposed to come up with alternatives to these old frames but they could never agree on it. They'd meet three times a year and wouldn't agree and they'd come and report to me that they couldn't agree.

I said, "Admiral, it isn't going to work at the DoD level. We can do it in the Navy, but we'll get push-back from DoD, Health Affairs."

He said, "I'll give you the cover you need." So, I talked to our head optometrist at Dahlgren, who by the way became an MSC flag officer in the Navy himself eventually, and we put together a plan to do a test of a couple of dozen types of frames on the *George Washington*.[53] We did the test and found out which frames the sailors liked best and we decided to go system wide. Then my Comptroller said, "This is going to cost us a couple of million dollars. How are we going to fit that in the budget?"

I said, "That's what you're for."

I asked, "How big is our budget this year?"

He said, "About $5 billion."

I said, "You expect me to believe you can't find a couple of million dollars slush in that budget? If that's the case I'm going to fire you."

So we did it. Of course, I soon got a phone call from Health Affairs telling me I couldn't do this.(*Harold who*

[53] USS *George Washington* (CVN-73), super-carrier commissioned in 1992.

***called, I don't remember this and I definitely supported you*) I said, "You can't stop me." And I did it. CNN and *The Navy Times* picked it up and it became so popular that the other three services were directed by Congress to do the same thing.**

One of my proudest achievements as Surgeon General had to do with a medical researcher, Captain Carl June[54] who was at the Navy Medical Research Unit[55] in Bethesda. He's now retired from the Navy and a full professor at UPenn. He's world famous in immunology. Just after I became SG Carl's wife was diagnosed with ovarian carcinoma and it had already spread. This was a death sentence, but Carl's a really smart guy, he was a hematologist-oncologist-immunologist. He was a Naval Academy graduate and a Rhodes Scholar. He told me, "I want to do a bone marrow ablation and then restore her with her own bone marrow that I will have banked and propagated in culture." He had the

[54] Carl H. June, MD is currently Director of Translational Research at the Abramson Cancer Center at the University of Pennsylvania, and is an Investigator of the Abramson Family Cancer Research Institute. He is a graduate of the Naval Academy in Annapolis, and Baylor College of Medicine in Houston, 1979. He had graduate training in Immunology and malaria with Dr. Paul-Henri Lambert at the World Health Organization, Geneva, Switzerland from 1978-79, and post-doctoral training in transplantation biology with Dr. E. Donnell Thomas at the Fred Hutchinson Cancer Research Center in Seattle from 1983 - 1986. He is board certified in Internal Medicine and Medical Oncology. He founded the Immune Cell Biology Program and was head of the Department of Immunology at the Naval Medical Research Institute from 1990 to 1995. He rose to Professor in the Departments of Medicine and Cell and Molecular Biology at the Uniformed Services University for the Health Sciences in Bethesda, Maryland before assuming his current position as of February 1, 1999. (source: www.afcri.upenn.edu/ourfaculty/june_bio.html)

[55] Naval Medical Research Institute (NMRI), Bethesda, Md. now the Naval Medical Research Center (NMRC) Silver Spring, MD.

technology to take a marrow sample from her, clean it up and cause the cells to increase in number in culture. George Washington Hospital said they could provide the isolation program and nursing support. It would cost $150,000 and they would let Carl do the procedure. I said, "Okay, let's do it" and signed the contract for it. I soon got the expected phone call from Health Affairs telling me I couldn't do it.(Again, Kappert and Champus opposed it and you talked to me and I said go for it) I said yes I could and I did it. It worked. Carl's wife was hospitalized for a couple of months. She lived another eight years. She did not die of recurrent disease but rather the complications of going through that kind of rigorous treatment. She got to raise her two boys with Carl and see them off to college, and they had a Mom all those years.

AS: That's incredible.

A: Carl's remarried now and has a child by his second wife. As a result of this case, the rules were changed allowing us to pay for procedures that were still considered experimental, but had hope. That was a wonderful achievement.

AS: You were SG when Admiral Boorda was CNO and sadly ended his life. How did you hear about his death?

A: That's a real sad story. A retired Public Health Service O-6 dentist committed suicide at Bethesda. He was a chronic alcoholic who had been through treatment and relapsed a dozen times. He'd gone on another bender for couple of weeks, and when he ran out of money he called an ambulance to take him to Bethesda. He claimed he was suicidal so he was admitted and taken through withdrawals. After withdrawals he signed a contract that he would not commit suicide, so he was taken off suicide watch and put on an open ward. He had an ex-wife who was a nurse at Bethesda who came to visit him. He asked her to take him back. They'd been divorced for years and she of course refused. He became despondent and left the ward, went to the parking garage and to the top floor and jumped.

Admiral Boorda had his EA call and ask me to talk with him about suicide in the Navy and how we went about investigating it. So I prepared an in-depth brief. On the appointed day and hour I went to the Pentagon and Admiral Boorda took me in his office and sent his EA out saying, "I want to talk to the SG privately about this. Then he told me to put my brief away. We sat and chatted about suicide in general and the Navy for 45 minutes.

The next day I was in a meeting with Ed Martin and the other SG's. My EA came in and gave me the news. Admiral Boorda had shot himself. I missed his cry for help completely.

That was really a sad day. When I look back there were warning signs. He had a lot of family problems to deal with. He was the only E-1 to advance to O-10; a non-Naval Academy grad who didn't have the support of a lot of the past CNOs nor the support of some of his fellow Admirals.

The final services for Admiral Boorda were held at the National Cathedral. Most in attendance were unaware that he was Jewish. Burial was private at Arlington, family only with one exception. Vice Admiral Jim Zimble, also Jewish, conducted the graveside services.

AS: In our photo archives we have a wonderful picture of you with Henry Heimlich.[56] It is my understanding that you and he became quite close during your time as SG. Can you tell us how this came about?

A: Henry had first come to visit my predecessor, Don Hagen, and then came back and visited me a couple times while I

[56] Henry Heimlich, MD (1920-), American thoracic surgeon widely credited as the inventor of the Heimlich maneuver and Heimlich chest valve.

was SG. I think your predecessor, Jan Herman,[57] did a couple of wonderful articles on him. Heimlich is an absolutely fascinating man. He's still alive. I had mentioned earlier to you that Deena and I have just come back from a European river cruise celebrating our 50th wedding anniversary. There were 98 people on our boat from Budapest to Amsterdam, and one was a woman who was a little older than me. She had been a friend of Henry since childhood. She planned to get in touch with him on her return. I gave her my card and told her to tell him she met me. He is a real gem. He has done so much in his life. Everyone knows about the Heimlich maneuver, but the maneuver is nothing compared to the Heimlich valve.[58] One other thing, people ought to read is Jan's articles[59] about Henry. Hardly anyone knows that Henry was a close friend of Mao Zedong. During WW II Henry had been a medical officer stationed in East China at a U.S. Weather Station. Mao's Army was operating in the area and Henry voluntarily took care of many of Mao's wounded troops. Henry visited Mao at least annually until Mao's death; through all the years we had no diplomatic relations with China.

[57] Jan K. Herman, Historian, BUMED, 1979-2012

[58] In the early 1960s, Heimlich developed the chest drain valve as a means of preventing collapsing lungs.

[59] Herman, Jan. Oral History with Dr. Henry Heimlich, 15 December 1994. Published in *Navy Medicine* Magazine, May-June 1995.

One other person I had a close relation with was former CNO, Admiral Zumwalt.[60] He would come by to visit every few months. My Mess Specialist would prepare a lunch for the two of us and bring it in on those dates. Of course, he would prepare way more than the two of us could eat, so that turned out a nice treat for my staff as well. Admiral Zumwalt came to visit because he was the main supporter of getting congressional appropriations for the National Bone Marrow Registry. The appropriation was always placed in the BUMED budget. (*I know that's hard for people to understand, but that's how Washington works*.) His interest in this went back to one of his sons who had died from a Lymphoma.[61] His son had been exposed to Agent Orange in Viet Nam, and Admiral Zumwalt always felt some responsibility for that. Once he found out I was a Hematologist-Oncologist we became friends.

AS: I want to talk briefly about your views on leadership. How would you describe your leadership philosophy?

A: I won't cover the normal things that people say, like "lead by example" and all that. I tried to be nice to people, but firm. I always tried to give them a task that I thought

[60] ADM. Elmo "Bud" Zumwalt (1920-2000), Chief of Naval Operations, 1970-1974.
[61] Elmo Russell Zumwalt, III died of lymphoma in 1988 at the age of 42 after a five-year battle with the illness.

they could accomplish, and I would encourage them that I wanted them to do it because I thought they would do it better than I could.

I learned this by watching people that I worked with. For instance, the CO I relieved in San Diego was one of the world's nicest people. He called all the corpsmen, nurses, and other officers by their first name and he expected them to call him by his. That probably contributed to a lot of the problems that developed in San Diego. So I told the command I was Captain Koenig, and when I walked on a ward or into a clinic, the first person to see me was to call,

"Attention on deck," and then I would respond with, "Carry on."

Instead of holding enlisted mast in my office with the door closed — or as it is called in the Army "office hours" — I moved it to the quarter deck so everybody could see it, just the way it's traditionally done on board ship. When I first got to San Diego there were about 20 mast cases a week. By the time I had been there six weeks we were down to zero; and I rarely had a mast case thereafter. So, part of my philosophy was to do things in the Navy tradition. I tried to be fair, if someone did something wrong and they were regretful about their actions, I was not above giving

them another chance, but if they came back again then they got what they could have gotten the first time plus what they got the second time. That earned me the afore mentioned nickname, "Koenig the Barbarian."

What impressed me about Navy medicine were its leaders. I learned that there were people senior to me who were always guiding me and making suggestions that pushed me along, and I tried to do that for people. I would do things that I thought would help them move along successfully in their careers, and I've seen a whole lot of them do it. I was always looking to build for the future.

AS: What do you think are the greatest failings of Navy medicine, or military medicine that you witnessed?

A: Overall, I'd have to give military medicine high grades. One of the negatives was the internal battles between the services. These were apparent even in the early part of my career. We really started to diminish this when I was serving as a DASD with the ASD(HA), Enriques Mendez. We got the services to work together a lot better than they had in the past.

One of the most significant events was the period between the Bush 41 and Clinton administrations; it took

almost a year and a half before Heath Affairs was repopulated with political appointees. One of the things that Ed Martin, who was acting ASD(HA), and I did was combine the Graduate Medical Education selection boards. That is where all the program directors came together and select the residents for the next year. Traditionally each service did this on their own, in a vacuum. We said, "You guys will all do it together. All the pediatricians, you're going to the same room and you're going to work together. All you internists, surgeons etc., have to work together.

You need to take some officers in different colored uniforms into your programs."

When I came into the Navy, we had the Berry Plan,[62] and we were enriched by all of the doctors that came in with training from a variety of places other than our own institutions. We don't have that to near the same degree since the end of the draft, so we needed to start doing this. One of the ways we could do it was to send some Navy officers to train in an Army program and vice-versa. Out of

[62] Armed Forces Physicians Appointment and Residency Consideration Program (or Berry Plan). Conceived in 1954 by Assistant Secretary of Defense for Health Affairs Frank B. Berry (1892-1976), the Berry Plan allowed for physicians to be deferred from military service while pursuing training in medical specialties that they would use in their two-year military commitment. The adoption of the all-volunteer military force in 1973 marked the end of the Berry Plan.

that came what Ron Blanck[63] and I did at Tripler. We agreed to make the second in command at Tripler a Navy O-6 and the opposite at Bethesda. I think those things helped overcome a lot of what I looked at as a sort of parochialism that promoted in-breeding.

When I was in Health Affairs I found there were military hospitals that would not honor prescriptions for people from the other military services. That was a lot harder nut to crack than it should have been, but we did it. The DHP, Defense Health Program, provided the tools needed.

Here is an example of service parochialism I had to deal with while in Health Affairs. There was an Air Force hospital in Lakenheath,[64] England, that wanted to replace Landstuhl as the major referral center for all Europe. They had a plan to build a hospital that was going to cost over $300 million. I had a really great staff office headed by an Army Colonel, Stu Baker,[65] a brilliant man, who by-the-way served as one of my side-boys at my retirement. Stu and his staff would put together a book for me on each facility I was going to visit. The book was built from the

[63] Lt. Gen. (ret.) Ron Blanck, MC, USA, Surgeon General of the Army, 1996-2000.
[64] RAF Lakenheath, Suffolk, UK
[65] COL (ret.) Stuart W. Baker, MSC, USA served in the Army from 1975 to 1999.

data the hospitals put into our several data systems. I would study that book and learn what went on in these places. I looked at Lakenheath's OB data, and spotted a real disconnect. They had about 50 deliveries a month, but their average daily census in the nursery was about 15. The standard of care then was two days in the hospital for a baby and the mother. That means they should have had four or five babies in the nursery on average. So when I called on the CO in his office I asked him, "Why do you have such a high census in your nursery and how long do you keep babies?"

He said, "We only keep them two days."

And I said, "This doesn't add up."

He said, "You got your numbers wrong."

I said, "I don't have my numbers wrong. These are your numbers. These are what you are submitting and how decisions are being made to justify building the $300 million facility you are asking for."

We then went on a tour of his hospital and when we got to the nursery there were 15 babies. I asked the Air Force Nurse Corps Captain there, "Why do you have so many babies in here."

She said, "This is what we normally have.'

I asked, "How many deliveries do you have a month?"

She said, "about 50."

I said, "That's roughly two a day." "And if they stay two days that should be four or five, right?"

She said, "No, it's command policy that all babieshave to stay seven days."

That was the end of Lakenheath's $300 million new construction project and the end of the Colonel's tenure as hospital commander.

I did a similar thing with new construction at Portsmouth and Fort Bragg. I found several military facilities that "fudged" their workload data to justify their budgets and construction projects. I looked at that as a significant failure in our system. People would ascend to positions of trust and fudge data. You didn't have to be a genius to figure this out. You only had to walk around and look to know something was wrong. I took 100 beds out of the replacement hospital at Portsmouth, Virginia. I thought I was going to lose my job or at least have no job back in the Navy when I did that. That went all the way to the Deputy Secretary of Defense for a final decision.

When he got the decision paper he was briefed by Enrique Mendez, the ASD(HA). The Deputy Secretary told the Secretary of the Navy they had 12 hours to get a letter on my desk accepting my decision or the whole project would be canceled. This would not go over well in Congress, but it would look even worse on the front page of the Washington Post. The new Portsmouth Hospital has 100 beds less than originally planned.

I did a similar thing with the Army's request for a new hospital at Fort Bragg.

Those are failures in military medicine, and there are many others.

One last one - Probably the crowning glory was stopping the construction of a new half-billion dollar replacement facility for Fitzsimmons Army Medical Center in Aurora, Colorado. That was so far off the charts that we got the facility on the BRAC list instead, and it was closed. Coincident with that, Pat Schroeder, the congresswoman from that district who had pushed this wasteful project so far along, decided to not run for re-election.

DG: Well, if we rolled to today we now do have a Defense Health Agency. What is your take on that?

A: I think it's going to help, especially because the resources will continue to be constrained. I feel we're still trying to recover from the base and infrastructure legacy of World War II. During that war we built up a huge infrastructure and we have spent the last 70 years trying to cut it down. Healthcare is a part of that. One of the difficulties we have with doing this is communities have become dependent on these bases for local civilian employment. But, if we want to maintain the benefits for people, we're going to have to use what we've got more efficiently and more effectively. We can do that by not having so many moving parts, and having more consistency in how we do things.

Let me give you an example. One of the things that Stu Baker found that we worked on was length of stay patterns in our hospitals. We found that there were vast differences for the same diagnosis between hospitals and between the services. I can remember presenting this to the service SGs in a meeting with Enrique Mendez and Ed Martin and saying, "Guys, we've got to straighten this out." The OB length of stay I sighted for Lakenheath is just one example. If we

can become more efficient by comparing data and looking for lack of uniformity, then we can eliminate inefficiencies in the system and have more resources to invest in other things. So, I think there's still a lot of opportunity.

DG: We're still winding down a long war in the Middle East, what do you see as the biggest advancements in military medicine coming out of that?

A: There have been a lot of them. If you consider what they've done for troops with amputations it's incredible. One of the big challenges is how to retain that. We got pretty good with dealing with amputations during World War II, and we lost a lot of that after World War II, Korea and Viet Nam because we weren't involved in anything like that. I think people are aware of that this time and they're trying to make sure that we don't lose that knowledge.

The other area that's probably even bigger is mental health, in particular the PTSD and TBI-related issues. There are huge family problems that are a direct result of these conditions. I don't think we've made as much progress as we should. I think we've tried things that were really not thought out. I think we're over-prescribing medication and I think we're getting a lot of people dependent and addicted. Certainly with the opiates we have an enormous

problem that has spread way beyond the military. We are too dependent on the use of those agents. I think there are other technologies and other ways of approaching management of some of these problems. I see that as an area that is lacking progress and proper study. We've become too dependent on pharmaceuticals. I have some ideas about where we should be going on this and I'm working on some of that now here in San Diego.

AS: Is there anything that excites you about innovations that are on the horizon now?

A: Oh yes, I think we probably have in our hands right now technology that can essentially cure most PTSD in two to four weeks. What bothers me is the services and the VA are very slow to even look at it, even on a trial basis.

I'll first give an example. Recall my mentioning earlier a USUHS Senior Medical Student who petitioned me to help him go straight into an ophthalmology residency rather than doing a utilization tour first? When I was SG, the CO of the Navy Medical Center, San Diego, Dick Nelson,[66] who became my relief as SG, came to my office with that same

[66] VADM Richard Nelson, Surgeon General of the Navy, 1998-2001.

doctor, CDR Steve Schallhorn, who was now an ophthalmologist and trained in refractive surgery. He wanted to start a study doing LASIK and PRK on servicemen to see if we could improve their visual acuity. I listened to his pitch and said, "Okay, let's do it. Let's make sure it's a good study and we can validate the results." That meeting and decision took just a half hour. Now LASIK or PRK is routine on many active duty personnel, making the problems with eyeglasses for them obsolete. But I don't see that willingness today.

AS: Why is that? Is there a fear of failure?

A: I think people in leadership positions today are scared to death. They're scared because of the way the government operates. They're afraid to make a mistake. Let the next guy make the mistake. They just want everything to be okay so they can get out and get their pension.

When I was SG we talked about risk taking, and rewarding risk taking and rewarding failure. If you do something stupid, that's one thing, but if you take a risk because it looks like there may be something good there and it doesn't work out, you shouldn't be punished for that. I think that there's a fear that they will be punished if it

doesn't work out. I think we're missing a lot of opportunity because of that.

DG: Backing up a second, sir, what is the technology in PTSD that you find so promising?

A: It's an enhancement of a technology that's been around for over 20 years called "trans-cranial magnetic stimulation." (TMS) It's being done in a few of our military hospitals, but with good results in only about 20% of cases. The reason is the way a standard TMS device works. The brain is pulsed at a frequency of 10 Hz, or 10 cycles per second. Normal brains in the awake state work at between 8 and 13 Hz, the average is 10. Each of us has our own preferred frequency. We have learned how to determine an individuals preferred frequency, somewhere between 8-13 Hz. We stimulate at that frequency instead of using the population average of 10. When you use the individuals preferred frequency you can enhance the chance of getting positive results from 20% to about 95%.

Think of your brain as having eight walkie-talkies in it, four on one side; four on the other. If those walkie-talkies are operating at different frequencies, your brain isn't going to talk between its different parts very well. In PTSD and a variety of other disorders, the various parts

of the brain get out of sync with each other, i.e., they aren't all broadcasting and receiving on the preferred frequency. So, if you're using this technology and only stimulating with TMS at 10.0, you're going to get about 20% of brains to respond to it. If you figure out what the preferred frequency is for a person, and you stimulate their brain at that frequency, your chance of good results go up to about 95%.

DG: Is that technology being used at all in the Navy, or in the NICoE, the National Intrepid Center of Excellence?

A: No, but we have presented it to the C5 unit in San Diego and several higher officials in military medicine. They are aware of it. We have treated many former Navy people, primarily from the special warfare community. Many have gotten out because their brains are messed up. We've even done, on the QT, a few active duty guys and gotten good results. When I was SG I would have been all over this like a wet blanket. The Marines are interested in it. But it's a struggle. It's more of a struggle than it should be.

DG: You're doing this as part of an organization?

A: Yes, we're doing it here in San Diego and Newport Beach. We are hoping to set up more. We're working to start up a clinic with the VA to deal with a lot of their patients.

DG: So what is the name of your organization?

A: It's called the "Del Mar Neuro-Center," because of its location. There's been a lot going on in there and I think it's really going to be exciting. Right now people are aware that it's there; that it's local and it's available. They just haven't dipped their toes in the water yet. They're still passing out buckets of pills to these service men and women and a lot of them are getting messed up. These pills are not innocuous; they're not without side effects. Some are blowing their brains out. What's the oft-quoted number, 22 vets commit suicide a day?

DG: Does Del Mar get any support from the VA or other services?

A: The VA is engaged. It took a meeting with Bob McDonald[67] that happened in September. It took a long time to get a meeting with him, but he understood it. It took him 15 minutes to get it."

[67] Robert McDonald, Secretary of Veterans Affairs, 2014-Present.

DG: Do you know of anyone who's taken on a more thankless job than he has?

A: Nope, I think that's probably the most thankless job there is in government right now.

AS: So, I guess as you look back now, is there anything you would want to change about your career?

A: One of the things I tell a person is if I could do my career again I would go to Rota, Spain. It is a wonderful place – and I went to every place Navy Medicine had a footprint during my tenure. I probably could have done a lot of things differently and it would have been a lot easier for my family and me. We made a number of cross-country moves in a short period of time; that was a really hard time for my wife and kids. The boys were in junior high and high school. To pick up and move every year and change schools was difficult. My oldest son went to a different school for ninth, tenth, eleventh, and twelfth grades, then to college, and he did okay. But those are the kinds of things that really were hard for us as a family. I'm glad I did them because I think I had a real impact on the system. I helped save Naval Hospital San Diego from some real embarrassment in the mid-1980's. It was hard on me and on my family. So, yes, if there were things I could

have changed I would have changed them, but if I hadn't changed them then what would have been the result? Not good probably.

DG: So what legacies are you most proud of today? You think the San Diego experience or your time as SG? What stands out?

A: I think the things that I did when I was a DASD, especially with regard to medical specialty pay, CHCS, military medical construction, BRAC and TRICARE were enormous. Those have had long-term and very significant impacts on the military and our beneficiaries, The SG job? Most people remember me for "Frames of Choice." They remember that because it had such a broad impact on sailors and Marines. But I think beyond that advancing telemedicine, and getting Tricare going in the services was much more significant. The automation at BUMED? I just pushed that ahead early. It would have happened; I just got it in there sooner than it would have otherwise.

AS: What sort of advice would you give someone entering the world of military medicine today?

A: I've got one that I am doing right now, a young lady in her last year of medical school at University of Michigan and in the HPSP who wants to talk to me. Deena and I will have

dinner with her soon. This happens quite frequently. People call and they're going to go to medical school or are already in and they want to know about the scholarship program. I tell them that I don't think there's any better place to practice medicine. If you can go through medical school and avoid having a huge educational debt to service during a significant portion of your professional life that's very important and you ought to take advantage of it. I really do think that practicing medicine in the military, and especially in the Navy, is probably as fulfilling as it can be anywhere.

Then I tell them that they shouldn't miss the chance to be involved in the operational side of medicine early in their careers, for some even before they do their specialty training. I think the opportunity to serve in an operational medical environment with the fleet, or the Marines or in the other services in a similar venue, is a wonderful experience. It's broadening and it helps them understand what they're going to do in the future. That's what I tell them.

I promised a few Tracy Malone stories before I finished. Here they are.

A few days after I became SG, one of my predecessors, Lou Seaton, unexpectedly died. His wife wanted the services held the next morning and wanted me to present the Flag. We got a late afternoon flight to Jacksonville, were picked up at the airport by the hospital CO and got a late snack before heading to the BOQ. We got our room keys from the front desk and retired.

The hospital CO wanted to have us eat breakfast in the hospital galley and then tour the hospital before the services. So at zero dark thirty we were back at the BOQ Quarter Deck. Tracy asked me what I had done with the basket of fruit in my room. I said there was no basket of fruit in my room, but there was in hers. Turns out we had slept in each other's room!

Here's one that happened in Kuala Lumpur, Malaysia. We were checking into a hotel for a Pacific Rim military medical meeting at which I was to speak. Tracy always took care of the check in/out processes; I'd hang back, grip, and grin, but keep an eye on her. Sometimes she'd have problems with male front desk personnel, especially in Asia. This was one of those occasions, so I went to the desk. She told me the desk clerk was trying to give her the Presidential Suite. She was insisting I should have

the Presidential Suite. The desk clerk said, "Madam has Presidential Suite, Admiral, has Honeymoon Suite." And indeed I did. It defies description.

The last I'll relate involves the final leg of an around the world trip, this from Bahrain to London connecting on to DC. This was back when we still had paper tickets for travel. Tracy's got lost while we were in Bahrain. We didn't discover this until we got to the British Airways counter at the Bahrain airport for our 0400 flight to London. The only option was to buy her a new ticket to London and straighten the problem out at the United counter there. I had a government issued American Express card, so I took care of that.

In London I explained the situation to United and they were accommodating. I got her ticket on to DC and told Tracy I would hold on to both of them.

As a three-star, I was allowed to travel in business class on international flights scheduled for more than five hours; Tracy always had to fly in back. What Tracy didn't know was United had given her a courtesy upgrade to sit with me on the flight home. When we got to our seats she told me she had never flown anything but coach on

commercial flights. This was a long 17-day trip, and a nice way to finish.

Before we close, I'd like to briefly mention my retirement decision and ceremony. I left after three years for several reasons including the stress of the job and a recurrence of my bladder cancer early in 1998. My urologist said that the stress of the job could certainly have contributed to this recurrence. I went through another surgery and course of chemotherapy at Bethesda. I have been disease free since.

I wanted to have my retirement ceremony at the Naval Academy on June 30, 1998—40 years to the day from when I had been sworn in as a Midshipman 4/c. I called the Superintendent, Admiral Charles Larson, who was about to retire, for the second time. He gave permission to hold it in Memorial Hall. On June 30th the Hall was packed. About 50 of my Naval Academy classmates came; I was the "last man over the side," the last member of the Class of '62 to retire. Some parents of my former patients were their, including now retired Captain Hank Dalton and his wife Penny, who came from Colorado.

According to my DD-214 I had served 32 years, 1 month and 4 days. But I wasn't counting.

AS: Admiral, thank you again for your time today.

A: My pleasure.